HEALTH PROFESSIONS EDUCATION FOUNDATION

Giving Golden Opportunities

ASSOCIATE DEGREE NURSING SCHOLARSHIP PROGRAM APPLICATION

TO BE COMPLETED BY APPLICANT: Please type or print clearly and legibly.

SECTION I – PERSONAL DATA

NAME: _____
FIRST MIDDLE LAST

MAILING ADDRESS: _____
STREET/P.O. BOX APARTMENT #

_____
CITY STATE COUNTY **(required)** ZIP CODE

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

E-MAIL ADDRESS: _____ CALIFORNIA DRIVER'S LICENSE/I.D. #: _____

SOCIAL SECURITY NUMBER: _____ BIRTH DATE: _____

SEX: ☐ MALE ☐ FEMALE ARE YOU A U.S. CITIZEN/PERMANENT RESIDENT? ☐ YES ☐ NO

ARE YOU A CALIFORNIA RESIDENT? ☐ YES ☐ NO

ARE YOU A PREVIOUS AWARDEE OF THE FOUNDATION? ☐ YES CONTRACT # _____ ☐ NO

PLEASE PROVIDE THE NAME OF YOUR CALIFORNIA STATE SENATOR AND CALIFORNIA STATE ASSEMBLY MEMBER.

STATE SENATOR: _____ STATE ASSEMBLY MEMBER: _____

PLEASE INDICATE WHERE YOU RECEIVED YOUR APPLICATION:

☐ SCHOOL ☐ INTERNET ☐ FOUNDATION OFFICE ☐ EMPLOYER

☐ OTHER (PLEASE SPECIFY) _____

PLEASE INDICATE YOUR ETHNIC BACKGROUND:

☐ African American ☐ Hispanic American ☐ Caucasian ☐ Other (Please Specify) _____

☐ Asian American ☐ Native American (Please Specify Tribal Affiliation and "Portion") _____

In addition to English, list any other languages you speak, read, or write fluently: _____

For official use only:			
Recd:	Cmpl / Inc:		Omitted: A/Pgs GDV EVF SAR TAX LoR Oth:
AppInquiry: (- -)		(- -)	HPEF Contact: for:
ıput By:	MUA: Yes / No		CT#
Reviewed By:			Comments:

PLEASE ANSWER ALL QUESTIONS IN THE SPACE PROVIDED (DO NOT ATTACH ESSAYS).

SECTION II - EDUCATION

_____ I am currently enrolled in an associate degree nursing program in California.

_____ I have been accepted to an associate degree nursing program for the _____ Term _____ Year.
Fall/Spring

NAME OF NURSING SCHOOL: _____

SCHOOL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PROGRAM DIRECTOR: _____ SCHOOL PHONE: ( ) _____

YEAR ENTERED: _____ EXPECTED GRADUATION DATE: _____
MONTH/YEAR MONTH/YEAR

WILL YOU ATTEND SCHOOL FULLTIME: ☐ PART TIME: ☐

SECTION III – PERSONAL BACKGROUND

A. DESCRIBE YOUR CAREER GOALS

What kind of work would you like to do immediately after graduation?

What kind of work do you think you'll be doing in five years?

What is your vision of your professional future in ten years?

SECTION III – PERSONAL BACKGROUND cont.

B. LIST YOUR EMPLOYMENT HISTORY FOR THE PAST 10 YEARS

Dates (Mo/Yr – Mo/Yr)	Hours/Week	Position	Employer	City, State	Description of responsibilities

C. List any community service or professional activities within the past two years. Include work with community-based organizations, student organizations, civic committees, political associations, or religious organizations. At least one of the two required letters of recommendations should come from an individual who is qualified to verify and assess one of the community and or professional activities listed below. **Do not include experience for which you received academic credit.**

Dates (Mo/Yr – Mo/Yr)	Hours/Week	Position	Organization	City, State	Description of responsibilities

PLEASE ANSWER ALL QUESTIONS IN THE SPACE PROVIDED (DO NOT ATTACH ESSAYS).

Years	City, County, State	Specify if Rural, Urban, Suburban, Reservation, Inner City, etc…	Socioeconomic Level (Poor, Middle-class, etc…)
Birth - 10			
10 – 20			
20 – 30			
30 - 40			
40 - Current			

DESCRIBE YOUR FAMILY STRUCTURE, ANY FAMILY CIRCUMSTANCES AND CHALLENGES.

HOW IS YOUR BACKGROUND RELEVANT TO YOUR INTEREST IN PURSING A NURSING CAREER?

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GRADUATION DATE VERIFICATION FORM
MUST BE COMPLETED BY THE NURSING PROGRAM DIRECTOR

The student named below is applying for a scholarship from the Health Professions Education Foundation. This form is required for the application to be considered.

Applicant's Name: _____

School of Nursing: _____

Address: _____

Year Entered: _____ Expected Graduation Date: _____
Month/Year Month/Year

Please comment on the student's performance and potential for academic success

Name (Please Print) _____ **Title** _____

Signature _____ **Date** _____

Phone Number ( )_____

Please check one:

_____	I certify that I am the Nursing Program Director .
_____	I certify that I am authorized to sign this document on behalf of the Nursing Program Director.

CHECK LIST : DID YOU INCLUDE?

_____ ALL SECTIONS (Pages 1-6) OF THE APPLICATION

_____ GRADUATION DATE VERIFICATION FORM W/ ORIGINAL SIGNATURE – **COMPLETED BY NURSING PROGRAM DIRECTOR OR AUTHORIZED PERSONNEL**

_____ **OFFICIAL** COLLEGE TRANSCRIPTS (AS STATED IN THE "APPLICATION REQUIREMENTS")

_____ 2 LETTERS OF RECOMMENDATION ON LETTERHEAD (AS STATED IN THE "APPLICATION REQUIREMENTS")

_____ FINAL STUDENT AID REPORT (SAR) OR SIGNED COMPLETE COPY OF 2001 FEDERAL TAX RETURN ALONG WITH W2s AND/OR 1099s.

NOTE: APPLICANTS ARE URGED TO CONTACT THE FOUNDATION OFFICE AT (916) 653-0860 or (800) 773-1669 AT LEAST 10 DAYS PRIOR TO THE FINAL FILING DATE TO VERIFY WHETHER HIS/HER APPLICATION WAS RECEIVED COMPLETE AND ACCURATE. THE FOUNDATION WILL NOT PLACE CALLS TO REQUEST ADDITIONAL INFORMATION OR CLARIFY ANY INFORMATION PROVIDED.

I certify that all statements in this application are complete and accurate. I also authorize the Foundation to verify any information included on the application form and/or the attachments submitted with the application. I understand that falsification or discrepancies in documentation submitted will disqualify my application and the Board of Registered Nursing will be notified.

Signature: _____ Date: _____

INCOMPLETE OR LATE APPLICATION PACKETS WILL NOT BE EVALUATED

RETURN APPLICATION TO:
HEALTH PROFESSIONS EDUCATION FOUNDATION
1600 9th Street, Suite 436
Sacramento, CA 95814